

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Medicaid
PO Box 240769
Anchorage, AK 99524-0769

Example 7a
Deductible,
Coinsurance,
and Other TPL

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Form with various fields: 1. MEDICARE/MEDICAID selection, 2. PATIENT'S NAME (Doe, Jane), 3. PATIENT'S BIRTH DATE, 4. INSURED'S NAME, 5. PATIENT'S ADDRESS, 6. PATIENT RELATIONSHIP TO INSURED, 7. INSURED'S ADDRESS, 8. PATIENT STATUS, 9. OTHER INSURED'S NAME, 10. IS PATIENT'S CONDITION RELATED TO, 11. INSURED'S POLICY GROUP OR FECA NUMBER, 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE, 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE, 14. DATE OF CURRENT ILLNESS, 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, 16. DATES PATIENT UNABLE TO WORK, 17. NAME OF REFERRING PROVIDER, 18. HOSPITALIZATION DATES, 19. RESERVED FOR LOCAL USE, 20. OUTSIDE LAB? CHARGES, 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, 22. MEDICAID RESUBMISSION CODE, 23. PRIOR AUTHORIZATION NUMBER, 24. A. DATE(S) OF SERVICE, B. PLACE OF SERVICE, C. EMG, D. PROCEDURES, SERVICES, OR SUPPLIES, E. DIAGNOSIS POINTER, F. CHARGES, G. DAYS OR UNITS, H. EPSDT Family Plan, I. ID. QUAL, J. RENDERING PROVIDER ID. #, 25. FEDERAL TAX I.D. NUMBER, 26. PATIENT'S ACCOUNT NO., 27. ACCEPT ASSIGNMENT?, 28. TOTAL CHARGE, 29. AMOUNT PAID, 30. BALANCE DUE, 31. SIGNATURE OF PHYSICIAN OR SUPPLIER, 32. SERVICE FACILITY LOCATION INFORMATION, 33. BILLING PROVIDER INFO & PH #

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MEDICARE SERVICE CENTER
901 40TH STREET S, SUITE 1
FARGO, ND 581032146

8

*Note: Your EOMB may be
formatted differently.*

**Example 7b
Deductible,
Coinsurance,
and Other TPL**

MEDICARE
REMITTANCE
NOTICE

ABC MEDICAL GROUP
PO BOX 4444
ANCHORAGE, AK 99501-1000

PROVIDER #: K0000BHXBK
DATE: 4/04/10
CHECK/EFT #: 183699999
PAGE #: 1

REND PROV	SERVICE DATE	POS NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME LIVINGSTON, JIM		HIC 987654321A	ACNT 11434-099999			ICN 1111987654321	ASG Y	MOA MA01 MA15		
1711111111 0320 032010		11 1	J1480		180.00	77.20	70.00	1.44	102.80	5.76
PT RESP 71.44			CLAIM TOTALS		180.00	77.20	70.00	1.44	102.80	5.76
ADJ TO TOTALS: PREV PD			INTEREST		0.00	LATE FILING CHARGE	0.00		NET	0.00
CLAIM INFORMATION FORWARDED TO: STATE OF ALASKA MEDICAID PROGRAM										

9



P.O. Box 240489
Anchorage, AK 99524

Note: Your EOMB may be formatted differently.

**Example 7c
Deductible,
Coinsurance,
and Other TPL**

Page C-20
Date of Payment: APRIL 6, 2008
Check Number: 0987654321
Payment Reference #: 1234567890123456
Provider Number: 200098765432
Provider Tax ID Number: 123123123
NPI ID: 1212121212

ABC MEDICAL GROUP
PO Box 4444
Anchorage, AK 99501-1000

**APRIL 6, 2010
DETAILED EXPLANATION OF PAYMENT**

Patient Name Subscriber # & PT Suffix Patient Account # Subscriber Name Claim # Provider of Service Product	SERVICE DATES	CODE/ MODIFIER	UNITS BILLED/ ALLOWED	APC/ APG/ DRG/ ROOM TYPE	BILLED CHARGES	INFORMATIONAL	PROVIDER	OTHER INSURANCE ADJUSTMENT	PATIENT LIABILITY	PAYABLE AMOUNT	REASON REMARKS
						AMOUNT ALLOWED	ADJUSTMENT (A) DISALLOWED (D)		FEE ADJUST (A) COB SAV APP (B) COINSURANCE (C) DEDUCTIBLE (D) FUNDING ACCT (F) INELIGIBLE (I) COPAY (P)		

DOE, JANE 1234567890 0812345 DOE, JANE 312894723498 ABC MEDICAL GROUP	032010 032010 Claim Total	J1480	1 / 1 Paid To: G		71.44 \$71.44	71.44 \$71.44	\$0.00	0.00 \$0.00	0.00 \$0.00	36.00 \$36.00	
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Our records indicate your current TAX ID as being 920009999

Reason Remarks Explanation

- E CONDITION ONSET DATE NEEDED BEFORE CLAIM CAN BE PROCESSED.
- X THE COORDINATION OF BENEFITS INFORMATION RECIEIVED IS INCOMPLETE. OTHER CARRIER PAYMENT INFORMATION IS NEEDED BEFORE CLAIM CAN BE PROCESSED.
- O BENEFITS NOT PROVIDED BECAUSE A MEDICAL PREMISES POLICY IS RESPONSIBLE. CONTACT CUSTOMER SVC IF BENEFITS ARE DENIED/EXHAUSTED.
- P THIS CLAIM IS A DUPLICATE OF A PREVIOUSLY SUBMITTED CLAIM FOR THIS MEMBER.
- S A DISCOUNT WAS APPLIED TO THIS CLAIM.
- T THE MEMBER'S OUT OF POCKET MAXIMUM WAS MET.
- B THE MEMBER'S COVERAGE WASN'T IN EFFECT ON THE DATE SERVICES WERE PROVIDED.
- M AMOUNT WHICH REIMBURSEMENT TO PROVIDER IS LESS THAN THE AMOUNT OF BILLED CHARGES.

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NUCCC UNIFORM CLAIM COMMITTEE 08/05

Medicaid
PO Box 240769
Anchorage, AK 99524-0769

**Example 8a
Coinsurance
Only**

CARRIER

PICA <input type="checkbox"/>		PICA <input type="checkbox"/>					
1. MEDICARE <input checked="" type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)				1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0600999999			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane				3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>			
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)				6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Doe, Jane				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
a. OTHER INSURED'S POLICY OR GROUP NUMBER 987654321A				a. INSURED'S POLICY GROUP OR FECA NUMBER Medicare			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/> 01 01 34				a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>			
c. EMPLOYER'S NAME OR SCHOOL NAME Retired				b. EMPLOYER'S NAME OR SCHOOL NAME Retired			
d. INSURANCE PLAN NAME OR PROGRAM NAME Medicare				c. INSURANCE PLAN NAME OR PROGRAM NAME Medicaid			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. Signature on File SIGNED DATE				11. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d. Signature on File SIGNED DATE			
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY			
17. NAME OF PROVIDER OR OTHER SOURCE Seuss, J. Doctor MD.				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. RESERVED FOR LOCAL USE A2 15.44				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 123 04				22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER				F. \$ CHARGE G. DAYS OR UNITS H. EPSOT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #			
1 03 20 10 03 20 10 11 99213				77.20 LTC N ZZ 123D00000X 180.00 1 N NPI 1234567890			
25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO.			
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				28. TOTAL CHARGE \$ 180.00			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Jim Livingston, MD SIGNED DATE				32. SERVICE FACILITY LOCATION INFORMATION ABC General Practice 1000 Main St Anchorage, AK 99507-1234			
29. AMOUNT PAID \$ 61.75				30. BALANCE DUE \$ 118.25			
33. BILLING PROVIDER INFO & PH # (907) 277-0000				a. 3333333333 b. ZZ193400000X			

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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**Example 8b
Coinsurance
Only**

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REMITTANCE
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NAME LIVINGSTON, JIM		HIC 987654321A	ACNT 11434-099999			ICN 1111987654321	ASG Y	MOA MA01 MA15		
1711111111 0320 032010		11 1	99213		180.00	77.20	0.00	15.44 102.80		61.75
PT RESP 15.44			CLAIM TOTALS		180.00	77.20	0.00	15.44 102.80		61.75
ADJ TO TOTALS: PREV PD			INTEREST		0.00	LATE FILING CHARGE	0.00	NET		61.75
CLAIM INFORMATION FORWARDED TO: STATE OF ALASKA MEDICAID PROGRAM										

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY N... UNIFORM CLAIM COMMITTEE 08/05

Medicaid
PO Box 240769
Anchorage, AK 99524-0769

Example 9a
Deductible Only

CARRIER

Form with 33 numbered sections. Circled numbers 1-7 highlight specific fields: 1 (PICA), 2 (Patient Name), 3 (Insured's I.D. Number), 4 (Signature on File), 5 (Charges), 6 (Total Charge), 7 (Balance Due).

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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**Example 9b
Deductible Only**

MEDICARE
REMITTANCE
NOTICE

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NAME LIVINGSTON, JIM		HIC 987654321A	ACNT 11434-099999			ICN 1111987654321	ASG Y	MOA MA01 MA15		
1711111111 0320 032010		11 1	99213		180.00	77.20	77.20	0.00	102.80	0.00
PT RESP 77.20			CLAIM TOTALS		180.00	77.20	77.20	0.00	102.80	0.00
ADJ TO TOTALS: PREV PD			INTEREST		0.00	LATE FILING CHARGE	0.00		NET	0.00
CLAIM INFORMATION FORWARDED TO: STATE OF ALASKA MEDICAID PROGRAM										

Completing the CMS-1500 Claim Form for Professional Medicare Crossover Paper Claims

Providers should complete the CMS-1500 for Medicare crossover paper claims as they would for non-crossover paper claims billing for Medicare. All required fields found in non-crossover claims are also required on crossover claims. Additional requirements for the Medicare crossover components of these claims are listed below.

Rule: Only one service line per document is permitted.

Additional requirements for Professional Crossover claims:

1.	Field 1:	Check both the Medicare and Medicaid box.
2.	Field 10d: <i>RESERVED FOR LOCAL USE</i>	Enter the Medicare pay date using the mm/dd/yy format.
3.	Field 11: <i>INSURED'S POLICY GROUP OR FECA NUMBER</i>	Enter the word "MEDICARE".
4.	Field 19: <i>RESERVED FOR LOCAL USE</i>	Enter the deductible amount using qualifier A1 and the coinsurance amounts using qualifier A2; use a space between the qualifier and the amount (e.g., A1 70.00 A2 1.44). If there was a third-party payment from a source other than Medicare, enter this amount using qualifier TP; use a space between the qualifier and the amount (e.g., A1 70.00 A2 1.44 TP 36.00).

Field 24, shaded part of line 1 (only one service, on one line, per claim form) contains:

5.	24f, shaded area: \$ <i>CHARGES</i>	Enter the Medicare allowed amount. Be sure to enter the decimal point.
6.	Field 28: <i>TOTAL CHARGE</i>	Enter the Medicare billed amount.
7.	Field 29: <i>AMOUNT PAID</i>	Enter the Medicare paid amount.
8.	The EOMB	A copy of the Medicare EOMB must be attached to the claim.
9.	The TPL EOMB	If there was a third-party payment from a source other than Medicare, a copy of the third-party EOMB must be attached to the claim.

For more information on completing the CMS-1500, download the appropriate claim form instructions at:
<http://medicaidalaska.com/providers/provupdates.shtml>.